

Goal of the Maine State Health Plan: Making Maine the Healthiest State

Public Health Work Group

Current Plans and Recommendations for a Statewide Public Health Infrastructure to Be Developed within Existing Resources over the Next 5 Years

Report to the Maine Legislature: Joint Standing Committee on Health and Human Services Joint Standing Committee on State and Local Government Joint Standing Committee on Criminal Justice and Public Safety 12.31.07

Maine's health care spending is the second highest in the nation, fueled in part by high rates of chronic illness. Nearly half of health care cost increases are attributable to five often preventable diseases: cardiovascular disease, diabetes, cancer, chronic lung diseases, and depression. Our public health system has an enviable track record of community partners, Maine CDC, and other statewide entities working together successfully to address such health problems as high teen pregnancy, infant mortality, and youth smoking rates.

This system holds a unique and important role in preventing disease and promoting good health. However, because of the fragmented funding and patchwork quilt of agencies it has built, there is a need for improved coordination and streamlining in order for the system to most effectively and efficiently address current and future health problems. Often driven by Federal requirements, community-based funding has been administered through a wide array of entities with over 500 different grants addressing some aspect of public health.

The 2005 State Health Plan charged the Public Health Work Group (PHWG) to implement a statewide community based public health infrastructure that works hand in hand with the personal health care system. In 2006 the Legislature enacted a resolve, LD 1614,¹ charging the PHWG with developing core competencies, functions, and performance standards for comprehensive community health coalitions. In 2007 the Legislature, through LD 1812,² again called on the PHWG to streamline administration, strengthen local community capacity, and assure a more coordinated system of public health. That legislation set forth requirements for membership on the Public Health Work Group to assure broad representation while limiting membership to forty people, who worked tirelessly over several years to make this plan a reality. A membership list is included in Appendix A to this report. In 2007 the Legislature also enacted LD 676,³ seeking a plan from Maine CDC, with input from the PHWG, to modernize the Local Health Officer system.

¹ LD 1614: http://www.maine.gov/dhhs/boh/phwg/C_LD1614.doc

² LD 1812: http://www.maine.gov/dhhs/boh/phwg/T_LD1812.doc

³ LD 676: <http://janus.state.me.us/legis/LawMakerWeb/externalsiteframe.asp?ID=280023188&LD=676&Type=1&SessionID=7>

This report addresses the Legislature's charges and describes the public health infrastructure, administered through eight districts,⁴ that includes Local Health Officers, Comprehensive Community Health Coalitions, district offices of Maine CDC, District Coordinating Councils, and a Statewide Coordinating Council. The system, for the first time, links and coordinates local, sub-state, and state public health activities using existing resources more efficiently. This system also includes representation from and links to the state and county emergency preparedness system.

An effective and efficient statewide public health system is critical to achieve the goal of the State Health plan - making Maine the Healthiest State. This requires coordinated planning and calls for certain other functions within the *10 Essential Public Health Services*⁵ to be carried out at the local, district and state level over the next five years and within existing resources.

Maine's Statewide Public Health System to Be Developed within Existing Resources over the Next 5 Years

Maine's public health infrastructure is designed to:

- A. Strengthen the statewide consistent delivery of Essential Public Health services to all Maine people.
- B. Achieve greater effectiveness and efficiency through coordination, collaborative planning, and leveraging of Maine's public health and private assets.
- C. Assure health disparities for vulnerable populations are being addressed.⁶
- D. Assure Local and District Health Improvement Plans inform and are informed by the State Health Plan.
- E. Coordinate assessment of local public health needs and the development, implementation, and evaluation of Local and District Health Improvement Plans.
- F. Assure accountability to local communities for fairness and transparency in the public health system.
- G. Assure accountability in the use of State resources for achieving the goals of the State Health Plan.
- H. Recognize, link with, and strengthen both governmental and non-governmental roles as part of the public health system at local, county, and state levels.

⁴ **Maine DHHS Districts:** http://www.maine.gov/dhhs/boh/phwg/S_HHSDs_Offices3.pdf

⁵ **Public Health Functions Project, 1994** <http://www.health.gov/phfunctions/public.htm>

⁶ **Health Disparities:** differences in the incidence, prevalence, mortality, and burden of diseases and other adverse health conditions that exist among specific population groups. (National Institutes of Health, 2000.)

"The Office of Minority Health and Health Disparities (OMHD) aims to accelerate CDC's health impact in the U.S population and to eliminate health disparities for vulnerable populations as defined by race/ethnicity, socio-economic status, geography, gender, age, disability status, risk status related to sex and gender, and among other populations identified to be at-risk for health disparities." (US Centers for Disease Control and Prevention, 2007.)

I. Comprehensive Community Health Coalitions

A major step in streamlining and assuring a more coordinated public health system was put in place in 2007 by integrating Healthy Maine Partnerships and Community Health Coalitions into one system of Comprehensive Community Health Coalitions that strengthen local public health capacity statewide.⁷ This streamlining resulted in over 100 state grants and contracts to health coalitions being bundled to 28 contracts.

Overview of Local Health Officer Proposed Changes

The Local Health Officer (LHO) system provides a linkage between state public health and every local municipality. It is a system that has been in place for over 100 years. The Legislature charged Maine CDC/DHHS with proposing revisions to assure the laws governing LHOs are appropriate for the 21st Century. *An Act to Modernize the Local Health Officer Statutes* (see Appendix B) has been endorsed by the PHWG and is presented as part of this report for consideration for introduction in the 2008 session of the Maine Legislature. The pending Act streamlines a myriad of statutory duties and removes redundancies, while strengthening and focusing the system on the local governmental functions related to controlling and reporting local public health nuisances and communicable disease threats.

Process

The Director of the Maine CDC conducted two surveys of LHOs in June and August of 2006. These surveys, previously reported on to the Criminal Justice and Public Safety Committee, gave us a snapshot of the backgrounds, scope of work, and employment situations of over 200 LHOs statewide. A subsequent meeting with 18 LHOs in Augusta in November, 2006 was helpful in defining a process for further discussions. In June, 2007 over 70 LHOs met in Augusta to review the recently-enacted statute setting forth requirements for education, training, and experience for LHOs.

Subsequently, Dr. Dora A. Mills, Chris Lyman from the Maine CDC, and Trish Riley (or another representative from the Governor's Office of Health Policy and Finance), hosted eight meetings with LHOs and related stakeholders, one in each of the Maine CDC/DHHS districts. These stakeholders included municipal elected and management officials, county government officials (including county commissioners and emergency management officials), hospital and health center staff, Comprehensive Community Health Coalition staff, and representatives from the two municipal health departments in Maine (Bangor and Portland). These meetings all occurred in the latter half of October 2007 and were held in Waterville, Ellsworth, Bangor, Caribou, Wells, Portland, Rockland, and Auburn. A total of over 100 LHOs attended these eight meetings.

⁷ **Consensus Recommendations for Comprehensive Community Health Coalitions:**
http://www.maine.gov/dhhs/boh/phwg/I_CCHC.Definition.Functions.Competencies.PerfStandards.Consensus.070108.pdf

Between the over 200 LHOs who responded to the surveys, the 90 who attended Augusta-based meetings, and the over 100 who attended one of the eight district meetings, we received a great deal of valuable input from LHOs and related stakeholders.

Outcomes

The following is proposed:

- a) Local Health Officers need to remain municipal-based employees who provide:
 - reporting to Maine CDC/DHHS of perceived local public health threats;
 - linking of town residents to Maine CDC/DHHS resources; and
 - mitigation of some types of unsanitary conditions (such as a tenant living in an unsanitary rental unit).
- b) Some redundant LHO statutes should be eliminated such as:
 - those that allow LHOs to provide immunization clinics (there is nothing in state law that says they cannot do so, even without this statute);
 - those that give LHOs the authority to address wolf hybrid issues (this is redundant with the animal control officer statutes); and
 - those that give LHOs the authority to deal with public health issues related to jails (the Maine CDC provides that, and the consensus among LHOs is that they are not qualified to do this).
- c) During a declared public health emergency, the LHOs will report to and assist the Maine CDC on issues related to the public health emergency.
- d) The statutory duties of LHOs should be re-formatted to make them easier to read and understand.
- e) Maine CDC Public Health Units within each DHHS district have been formed and consist of co-located Public Health Nurses, District Nurse Epidemiologists, Health Inspectors, Drinking Water Engineers, and District Public Health Liaisons. These Public Health Units may perform certain public health functions that are more efficiently and effectively provided by them, such as some district or county-level functions and some public health emergency functions (see page 7 of this report).
- f) In the case of public health emergencies, the District Public Health Liaisons will serve in the county emergency operations centers (EOC) as liaisons between state and local public health entities. In those districts that consist of multiple counties, the District Nurse Epidemiologist and/or Public Health Nurses may also serve as EOC liaisons as well as back-up to the District Liaison.

Additionally, the Maine CDC is promulgating major substantive rules to comply with Public Law, Chapter 462, to set the requirements for training, education, and experience of LHOs. Those should be ready for the Legislature's review by mid-January, 2008. A copy of the proposed statutory language to modernize the statutes governing local health officers is attached as Appendix C to this report, Appendix D is an agenda for the October 2007 LHO forums held in each of the eight CDC/DHHS districts, and Appendix E is the form used to obtain feedback from LHOs.

Statewide Coordinating Council (SCC)

A Statewide Coordinating Council (SCC) will build on the work of the PHWG to implement a statewide public health infrastructure that streamlines administration, strengthens local community capacity, and assures a more coordinated system for delivery of essential public health services. The SCC will be the representative body for review and guidance to the Maine CDC on strategic state level policies related to the aligned system of Local Health Officers, Comprehensive Community Health Coalitions, District Coordinating Councils, and on other policy issues directly related to public health infrastructure, roles and responsibilities, system assessment and performance, and national accreditation.

The Statewide Coordinating Council will be appointed and convened by the Maine CDC and Governors Office of Health Policy and Finance and will include a member from each District Coordinating Council. The SCC will meet at least quarterly and will report annually on the status of Maine's public health infrastructure to the Governors Advisory Council on Health Systems Development and the Legislature's Health and Human Services Committee.

District Maine CDC/DHHS Units

An effective and efficient statewide public health system requires coordinated planning and calls for certain other functions to be carried out at the district level.

To improve the administration of state programs and policy and to assure state policy reflects the different needs in each of the eight DHHS districts, Maine CDC will out-station worker and co-locate existing district workers, and establish District Maine CDC/DHHS units. These will be linked to District Coordinating Councils. The Maine CDC/DHHS Units are to include:

- a) Public Health Nurses: who provide personal care and population health services including maternal/child health home visits, and vaccination clinics, who participate in addressing disaster preparedness or local infectious disease outbreaks, and who participate in identifying needs and gaps in access to care in the community.
- b) District Field Epidemiologists: who provide local surveillance and investigation of infectious disease outbreaks.
- c) Health Inspectors: who inspect and license a variety of facilities such as eating establishments, lodging facilities, swimming pools, and youth camps, who work closely with municipal code enforcement officers, and who assist in investigating outbreaks.
- e) Local Public Health Liaisons:⁸ who provide a direct link with the public health district, representing the Maine CDC and providing public health leadership, who help coordinate state public health functions at the district level, provide technical assistance and consultation to districts in public health planning efforts, and who provide public health assistance to Local Health Officers, County Emergency Management, and other entities.

District Coordinating Councils (DCC)

⁸ **Local Public Health Liaison position description:** <http://www.maine.gov/dhhs/jobs/psc2.htm> The Maine CDC will designate workers as "point persons" in each district until such time as Liaison positions are filled.

As part of Maine's public health infrastructure, District Coordinating Councils (DCCs) will be designated by the Maine CDC based on recommendations from each of the eight districts and with review and comment by the Statewide Coordinating Council. DCCs will:

1. Be the district-wide representative body for collaborative planning and decision-making for functions that are more efficiently and effectively accomplished at the district level.
2. Perform, through its members, some of the specific functions within the 10 Essential Public Health Services at the district level.
3. Mobilize working partnerships in which efforts and resources are combined within the district in order to produce results that no one community, organization or sector could achieve effectively or efficiently alone.
4. Include members from or representing:
 - Maine CDC/DHHS
 - County Governments
 - Municipal Governments
 - City Health Departments
 - Hospitals
 - Emergency Management Agencies
 - Emergency Medical Services
 - Tribes
 - Comprehensive Community Health Coalitions/Healthy Maine Partnerships
 - School Districts
 - Local Health Officers
 - Institutions of Higher Education
 - Health Care Providers
 - Clinics and Community Health Centers
 - Voluntary Health Organizations
 - Family Planning Organizations
 - Area Agencies on Aging
 - Mental Health Services
 - Substance Abuse Services
 - Community-Based Organizations, Issue-Specific Coalitions, and Civic Groups
 - Others
5. Have governance and leadership competency including:
 - a. Agreed upon operating principles and transparent decision-making.
 - b. A small volunteer Steering Committee charged with convening, agendas, and overseeing communications.
 - c. Linkage with the Maine CDC/DHHS Local Public Health Liaison.
6. Through its members, have competency in:
 - a. District-wide convening, fostering collaboration, and mobilizing across communities, organizations, and sectors.
 - b. Leveraging local assets and securing external resources such as contracts, grants, and in-kind goods or services.
 - c. Interpretation and use of health assessment data.
 - d. District-level and issue-specific planning.
 - e. Evaluation design, analysis, and use of evaluation findings.
 - f. Use of the Internet and other skills and channels for effective communications.

- g. Working with fiscal agents capable of accepting and administering funds on behalf of the district as a whole.

District Functions within the Ten Essential Public Health Services

Note: Responsibility for each function at the district level is assigned to the District DHHS Unit, to the DCC, or is identified as a shared DHHS/DCC responsibility.

EPHS #1: Monitor health status to identify community health problems.

- 1.1 Assure⁹ district-wide coordination and consistency for community health status monitoring, local health assessments,¹⁰ and in the development of Community Health Profiles¹¹ including the identification of disparities in population health status within and between districts. **Responsible: DHHS**
- 1.2 Promote the alignment and linkage of local, district, and state data systems. **Responsible: DHHS/DCC**
- 1.3 Promote broad-based participation in community health status assessments and collaborate with all relevant entities to collect, analyze, and disseminate data. **Responsible: DCC**
- 1.4 Coordinate the development of a District Health Profile based on key indicators identified in the State Health Plan. **Responsible: DHHS/DCC**

EPHS #2: Diagnose and investigate health problems and health hazards in the community.

- 2.1 Carry out surveillance and investigation of outbreaks as per delegation of authority by the state. **Responsible: DHHS**
- 2.2 Participate in emergency and all hazards preparedness planning and carry out roles in partnership with officially recognized federal, state, and local authorities. **Responsible: DHHS/DCC**

EPHS #3: Inform, educate, and empower people about health issues.

⁹ **Assurance:** One of the core functions of public health, *assurance* refers to the process of determining that “services necessary to achieve agreed upon goals are provided, either by encouraging actions by other entities (public or private sector), by requiring such action through regulation, or by providing services directly.” (Institute of Medicine Committee for the Study of the Future of Public Health. *The Future of Public Health*. Washington, DC: National Academy Press; 1988.)

¹⁰ **Local health assessments:** Per National Association of County and City Health Officials’ (NACCHO’s) *Mobilizing for Action through Planning and Partnerships* (MAPP) Tool:

- a. Community Themes and Strengths Assessment
- b. Local Public Health System Assessment
- c. Community Health Status Assessment
- d. Forces of Change Assessment

¹¹ **Community health profile (CHP):** A comprehensive compilation of measures representing multiple categories, or domains, that contributes to a description of health status at a community level and the resources available to address health needs. Measures within each domain may be tracked over time to determine trends, to evaluate health interventions or policy decisions, to compare community data with peer, state, national or benchmark measures, and to establish priorities through an informed community process. (*NPHPSP: National Public Health Performance Standards Program Glossary*)

- 3.1 Ensure that culturally and linguistically appropriate public health information, public health programs, and health promotion activities include vulnerable populations and are effectively and efficiently distributed district-wide through collaborative networks with all relevant entities. **Responsible: DHHS/DCC**

EPHS #4: Mobilize community partnerships to identify and solve health problems.

- 4.1 Convene and facilitate partnerships¹² among all relevant entities for district programs and initiatives. **Responsible: DCC**
- 4.2 Organize and facilitate a communications system among all relevant entities within and across districts. **Responsible: DHHS/DCC**
- 4.3 Mobilize partnerships to leverage new and existing resources. **Responsible: DCC**

EPHS #5: Develop policies and plans that support individual and community health efforts.

- 5.1 Develop a District Health Improvement Plan integrating the District Health Profile, District Public Health System Assessment, State Health Plan¹³ and local Community Health Improvement Plans¹⁴ and priorities. **Responsible: DHHS/DCC**
- 5.2 Facilitate district input to and communication about the State Health Plan. **Responsible: DCC**
- 5.3 Facilitate development and coordination of plans and policies, laws, regulations, ordinances, and codes within and across districts. **Responsible: DHHS/DCC**

EPHS #6: Enforce laws and regulations that protect health and ensure safety.

- 6.1 Carry out health inspection and licensing activities as per delegation of authority by the state. **Responsible: DHHS**

¹² **Community partnerships:** A continuum of relationships between and among the local public health system and its constituents that foster the sharing of resources, responsibility, and accountability in community health improvement and undertaking advocacy for capacity development and the delivery of community health services and improving community health. Partnerships are formed to assure the comprehensive, broad-based improvement of health status in the community. (NPHPSP)

¹³ **State Health Improvement Plan:** A state health improvement process is a collaborative effort to identify, analyze, and address health problems in a state; assess applicable data; develop measurable health objectives and indicators; inventory statewide health assets and resources; develop and implement coordinated strategies; identify accountable entities; and cultivate state public health system “ownership” of the entire process. The results of the state health improvement process are contained in a written document, the State Health Improvement Plan. (NPHPSP)

¹⁴ **Community Health Improvement Plan:** A long-term, systematic effort to address health problems on the basis of the results of assessment activities and the community health improvement process. This plan is used by health and other governmental education and human service agencies, in collaboration with community partners, to set priorities and coordinate and target resources. A health improvement plan is critical for developing policies and defining actions to target efforts that promote health. It should define the vision for the health of the community inclusively and should be done in a timely way. (Adapted from: United States Department of Health and Human Services. *Healthy People 2010*. Washington, DC: US Department of Health and Human Services; 2000.) See also *Community health improvement process*.

- 6.2 Provide communities with technical assistance on issues related to public health law. **Responsible: DHHS**
- 6.3 Identify, recommend and advocate for improvements in enforcement of state public health policies, laws, and regulations across the district. **Responsible: DHHS/DCC**

EPHS #7: Link people to needed personal health services and assure the provision of health care when otherwise unavailable.

- 7.1 Develop and support strategies within and across districts to close gaps in access to personal health services as specifically identified within the District Health Improvement Plan. **Responsible: DCC**

EPHS #8: Assure a competent public health and personal health care workforce.

- 8.1 Coordinate and provide for district-wide training, and technical assistance on public health and personal health care evidence-based practices as specifically identified within the District Health Improvement Plan. **Responsible: DHHS/DCC**
- 8.2 Develop and support recruitment, education, training and retention strategies as specifically identified within the District Health Improvement Plan. **Responsible: DHHS/DCC**

EPHS #9: Evaluate effectiveness, accessibility, and quality of personal and population-based health services.

- 9.1 Assure coordination and consistency for district public health system assessments within and between districts. **Responsible: DHHS**
- 9.2 Promote broad-based participation in district public health system assessments and collaborate with all relevant entities to collect, analyze, and disseminate data. **Responsible: DCC**
- 9.3 Coordinate and build capacity for high-quality program, organizational, and system evaluation¹⁵ within the district. **Responsible: DHHS/DCC**
- 9.4 Provide input to evaluation design and promote district-wide participation in evaluation activities. **Responsible: DCC**
- 9.5 Promote use of evaluation findings in development and revision of District Health Improvement Plans. **Responsible: DHHS/DCC**

EPHS #10: Research for new insights and innovative solutions to health problems.

¹⁵ **Evaluation:** Systematic approaches to determine whether stated objectives are being met. (Brownson, Baker and Novick, *Community-Based Prevention: Programs that Work*, Gaithersburg, MD: Aspen Publishers; 1999)

- 10.1 Promote district-wide participation in research as specifically identified within the District Health Improvement Plan or the State Health Plan and in other research initiatives as appropriate. **Responsible: DCC**
- 10.2 Promote use of research and promising practices to modify and develop public health policies, initiatives, and programs. **Responsible: DHHS/DCC**